CORRESPONDENCE

Is It Right ASA Scoring to be Used in Identification of Nonoperated Patients?

Although with limited number of patients, we appreciate the authors for their study investigating the rates of rupture and mortality that was developed in inoperable abdominal aortic aneurysm.[1] First we wanted to state a technical mistake in the paper that drew our attention. Despite the total number of patients included in the study is 72, there are 71 patients in Figure 1. Since the number of patients is small, we believe that this missing patient should be included in the relevant group. However, our actual review about the article is that the authors grouped the patients according to the ASA and gave the number of deaths and ruptures of these groups. Several studies reported ASA scoring to be effective both on anesthesic and surgical outcome.[2,3] However, we believe that this parameter which is used in preoperative risk scoring should not be used to identify nonoperated patients. Already looking to Figure 1, survival rate in the ASA 4 group (48%) is seen to be unexpectedly higher than ASA 2 group (38%). This shows us that evaluation of the risk for rupture and mortality between ASA groups is meaningless. We would want to say that we wonder about the views of the authors on our this critics.

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Re. 'Is It Right ASA Scoring to be Used in Identification of Nonoperated Patients?'

Sir,

We thank Dr Gokalp and colleagues for their interest in our paper on palliation of aortic aneurysms. Our study contained 72 patients however, we were unable to determine cause of death in one individual as they died abroad and therefore we were unable to include them in the analysis of cause of death.

ASA grade has been used in many studies to stratify surgical risk.[1,2] ASA grade is only one factor considered in our unit when deciding suitability for aneurysm repair and, unsurprisingly, the majority of patients included in this study were ASA-3 (41) or ASA-4 (22). Of the small number of ASA-2 patients (8), five declined operative intervention, some of whom would have been suitable candidates for aneurysm repair, so possibly changing subsequent outcome (25% of this cohort died of rupture). We therefore feel that as the majority of this group in our study self-selected themselves out of surgery, they cannot be seen as representative in terms of outcome.

Following assessment by a Consultant Vascular Surgeon, patients in our unit are subjected to CPEX testing and Consultant Anaesthetist review. This was not consistent in the early days of our CPEX programme but is standard practice now. All these factors are combined to give a definitive judgement on suitability for intervention at this point in time. This can be revisited in the future if aneurysm expansion shifts risk-benefit ratio in favour of surgery.

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Re. 'An Online Patient Completed Aberdeen Varicose Vein Questionnaire Can Help to Guide Primary Care Referrals'

We read with interest the study by Ward et al. concerning an online completion of the disease specific quality of life Aberdeen Varicose Vein questionnaire (AVVQ).[1] The study is thought provoking however surely the use of a non-validated tool renders such extrapolations moot. Without the original full questionnaire no comparisons can be drawn. Multiple other questionnaires exist which do not require a drawing such as Chronic Lower Limb Venous Insufficiency Questionnaire (CIVIQ)[2] or Specific Quality of Life and Outcome Response — Vascular (SQOR-V).[3] Additionally, construction of an online drawing tool is now well within our technological grasp.

CEAP grade 4—6 showed a high prevalence in this study (42%) with a consequently high average VCSS (mean 18.6). However, this is not reflected in the AVVQ scores (mean 21.8). Additionally the correlation for CEAP and AVVQ scores is not documented — is this clinically as well as statistically significant? Previous work in our unit has shown good correlation between the AVVQ and CEAP, and AVVQ and generic quality of life measures, but poor correlations between VCSS and AVVQ; VCSS and (SQOR-V); and AVVQ and SQOR-V.[4] Current work being undertaken in our unit has shown excellent correlation between CIVIQ and AVVQ.[5]

Most concerningly, however, is the number of patients with C2S disease (symptomatic disease) for whom the authors feel it is appropriate to deny intervention (47% of their cohort). This is in disagreement with extensive work that details the progression of venous disease[6] and the cost of treating only complicated disease,[7] not to mention the significant quality of life impairments seen with symptomatic disease[8] which improve with treatment.[9] Finally, it has previously been shown that treating uncomplicated venous disease leads to a greater improvement than leaving the disease to progress to permanent damage[10] — the very patients excluded have the most to gain.

Yours Sincerely,

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Response to 'Re. An Online Patient Completed Aberdeen Varicose Vein Questionnaire Can Help to Guide Primary Care Referrals'

Messers Lane, Franklin and Davies have provided additional points for discussion which should be considered if the study is to be repeated. The topic of limiting healthcare is controversial and we are not surprised that our article attracted their response.

We agree that the use of the on-line AVVQ tool will result in patients with C2 disease being denied access to state funded healthcare with the potential outcomes described. It was not our decision to limit access to healthcare but that of the commissioners who set a budget that they could afford. Whether we agree with the concept of limiting the treatment of venous disease to certain groups was not